GUIDE TO CREATING POSTER PRESENTATIONS

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Philadelphia, PA

NO DISCLOSURES

GOALS

- Review scientific research and clinically academic poster design
- Teach residents how to create scientific research and clinically academic posters

OBJECTIVES

Why?

Purpose of scientific research and clinically academic posters

What?

Components of a poster

Who/When?

Rules and requirements

How?

Conception and creation

WHY: PURPOSE

- Convey research and clinical cases to an audience using visuals and text
- Meet and speak informally with viewers allowing for idea exchange and networking
- Prepare for publication in peer-reviewed journals
- Create a safe environment of inquiry

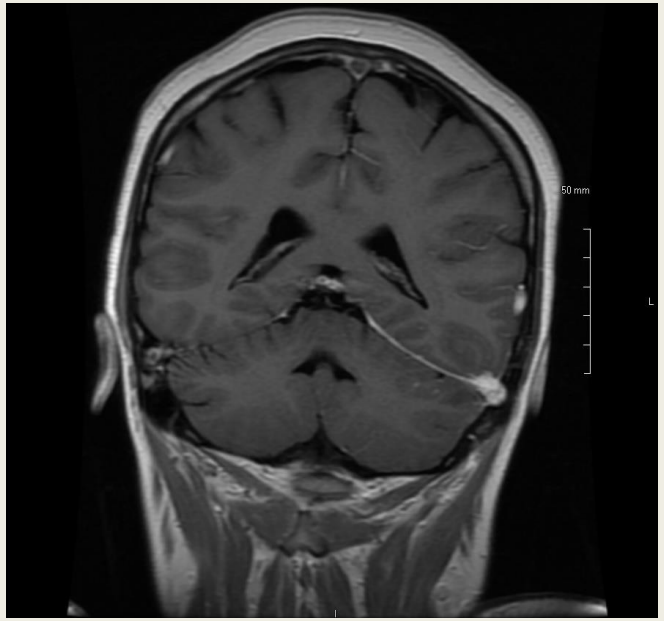
WHO AND WHEN:
RULES AND REQUIREMENTS

- Audience, Judging Criteria, Word Limits
- Poster Size, Display Requirements
- Date and Time of Presentation

WHAT: COMPONENTS OF A POSTER

Research Study

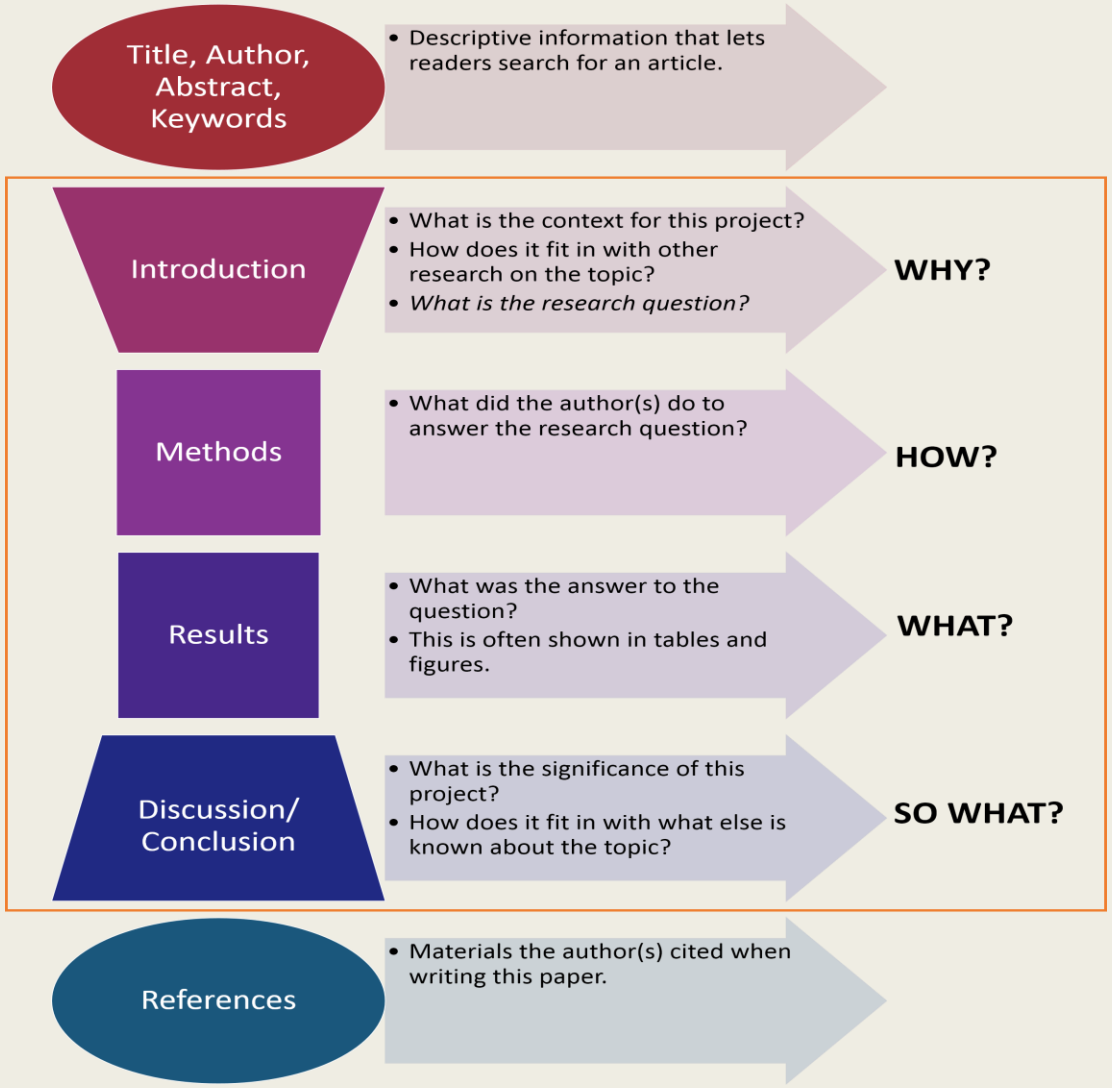
Clinical Vignette



RESEARCH STUDY: FORMAT

"IMRAD"

- Introduction
- Methods
- Research
- Discussion



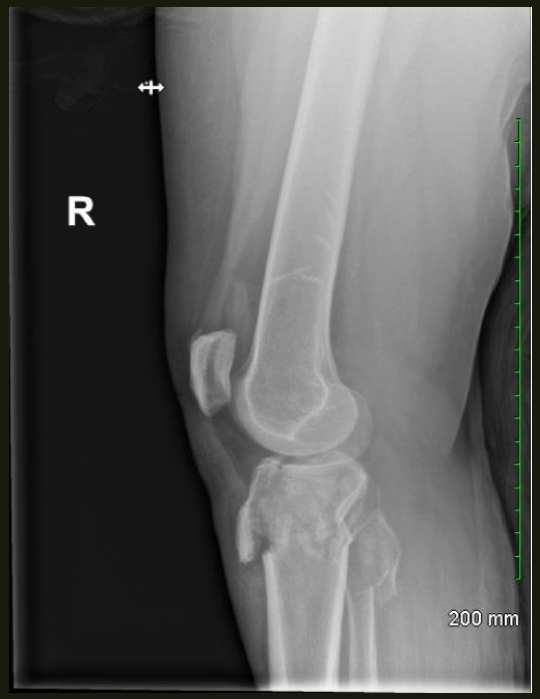
RESEARCH STUDY: FORMAT

"IMRAD"

- *Introduction*
- *Methods*
- *Research*
- *Discussion*

CLINICAL VIGNETTE: FORMAT

- Introduction
- Case Description
- Discussion



CLINICAL VIGNETTE: FORMAT

- Introduction
- Case Description
- Discussion

Case Description

History

Physical Exam

Investigative Studies

Patient Progress

Outcome

Case Discussion

- What **clinical decisions** were made?
- What **can be learned** from this case?
- Make a few **key points** and explain them clearly and succinctly.

ABSTRACT vs. CONCLUSION/DISCUSSION (not the same/prevent redundancy)

- **Abstract**
  - *Written for the potentially interested reader*
  - *Give an impression of what the paper will be about*
  - *No jargon or abbreviation use*
  - *Answer the Question "WHAT?"*
  - *Understandable for specialists and people from all fields*
- **Discussion/Conclusion/Summary**
  - *Conclude the research or case*
  - *Written for the reader who has already read the poster*
  - *Answer the Question "SO WHAT?"*

HOW: CONCEPTION AND CREATION

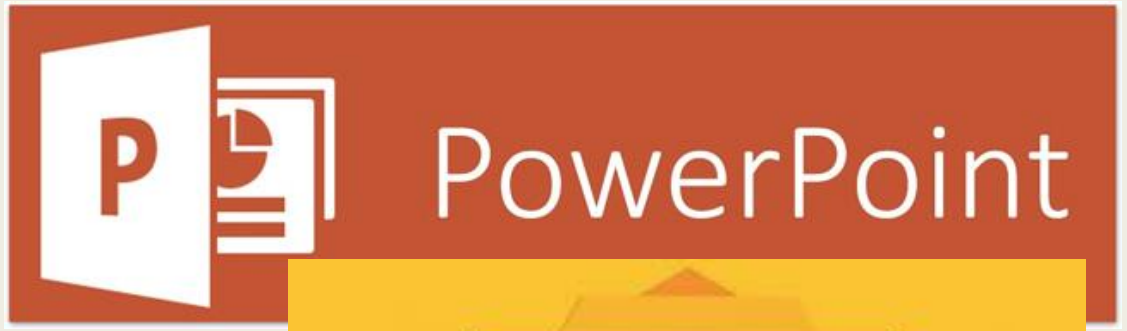
SOFTWARE

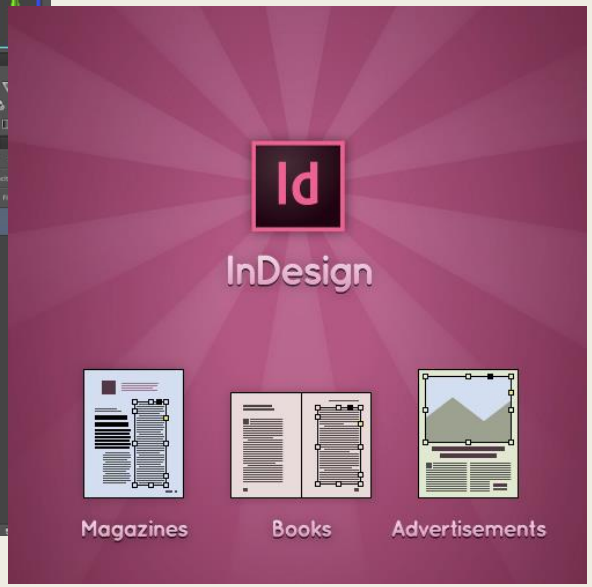
PowerPoint

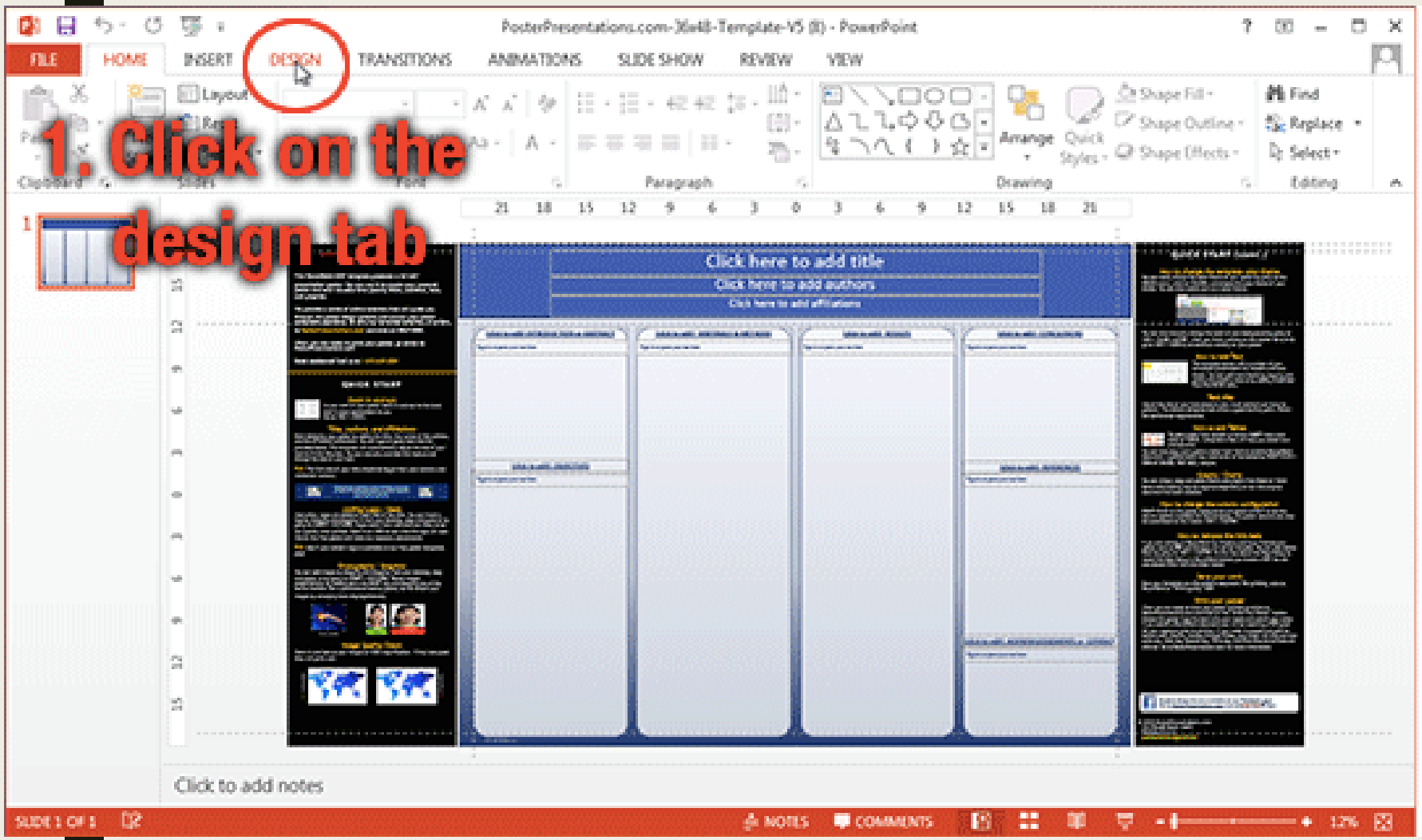
Adobe Illustrator

Photoshop

InDesign



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Scans

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Methods

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Yyyxx.

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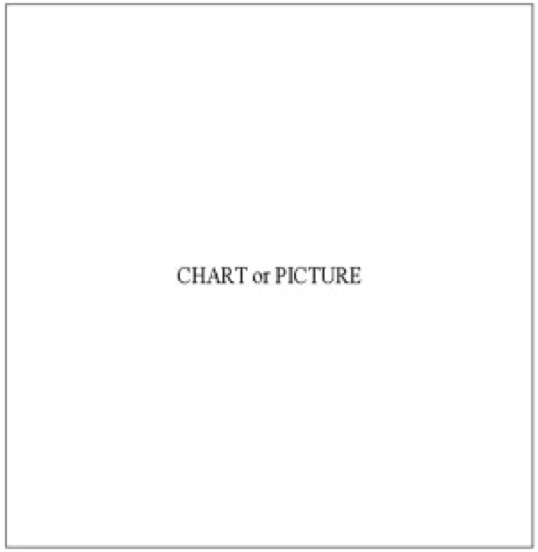

Results

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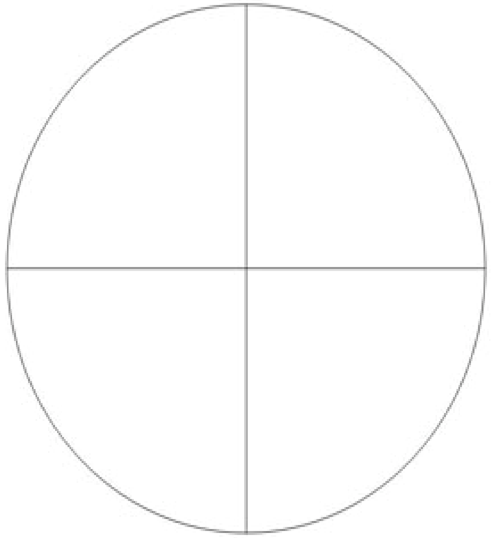
Figure #2



Conclusions

Xxxx

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Bibliography

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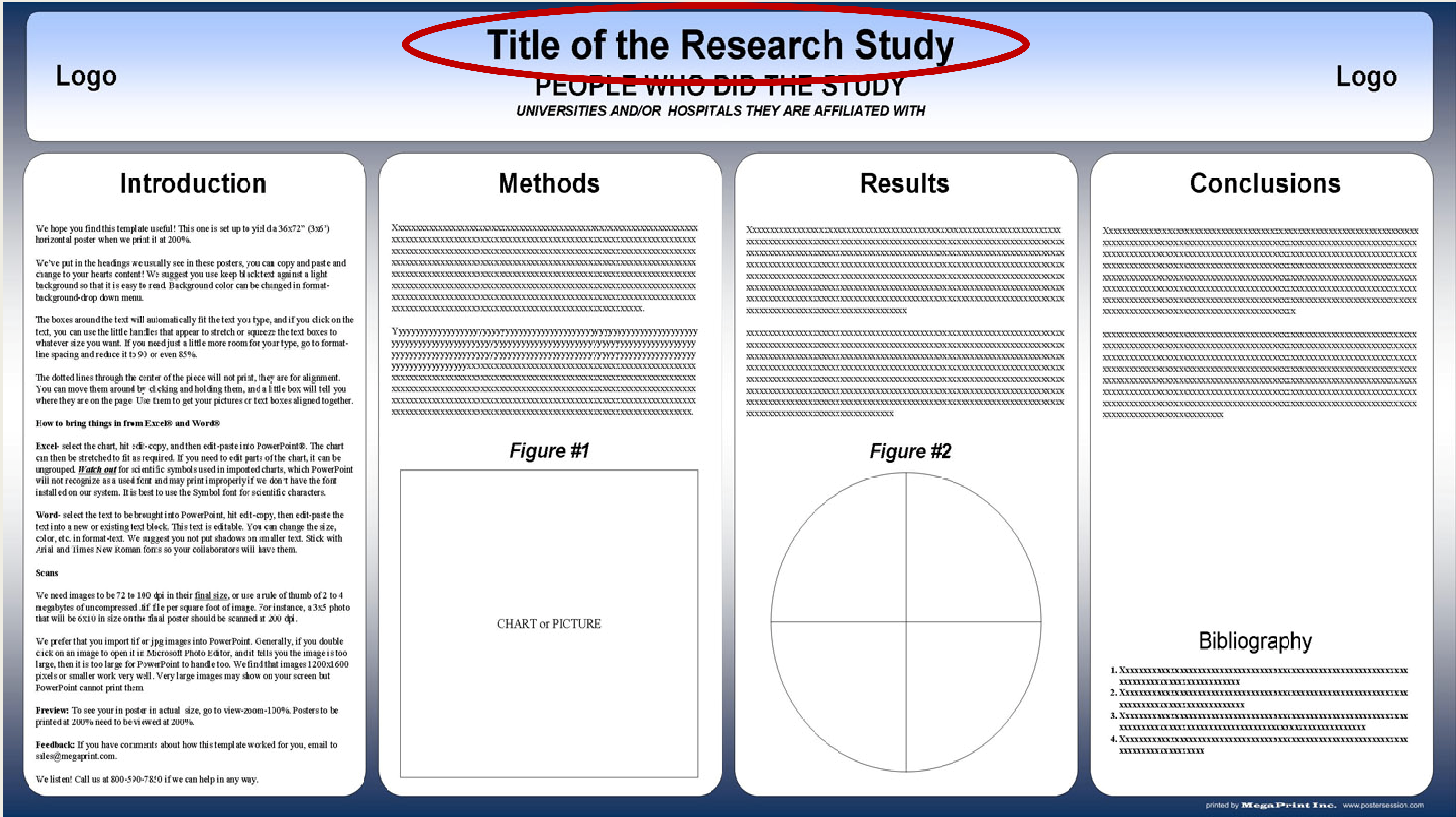
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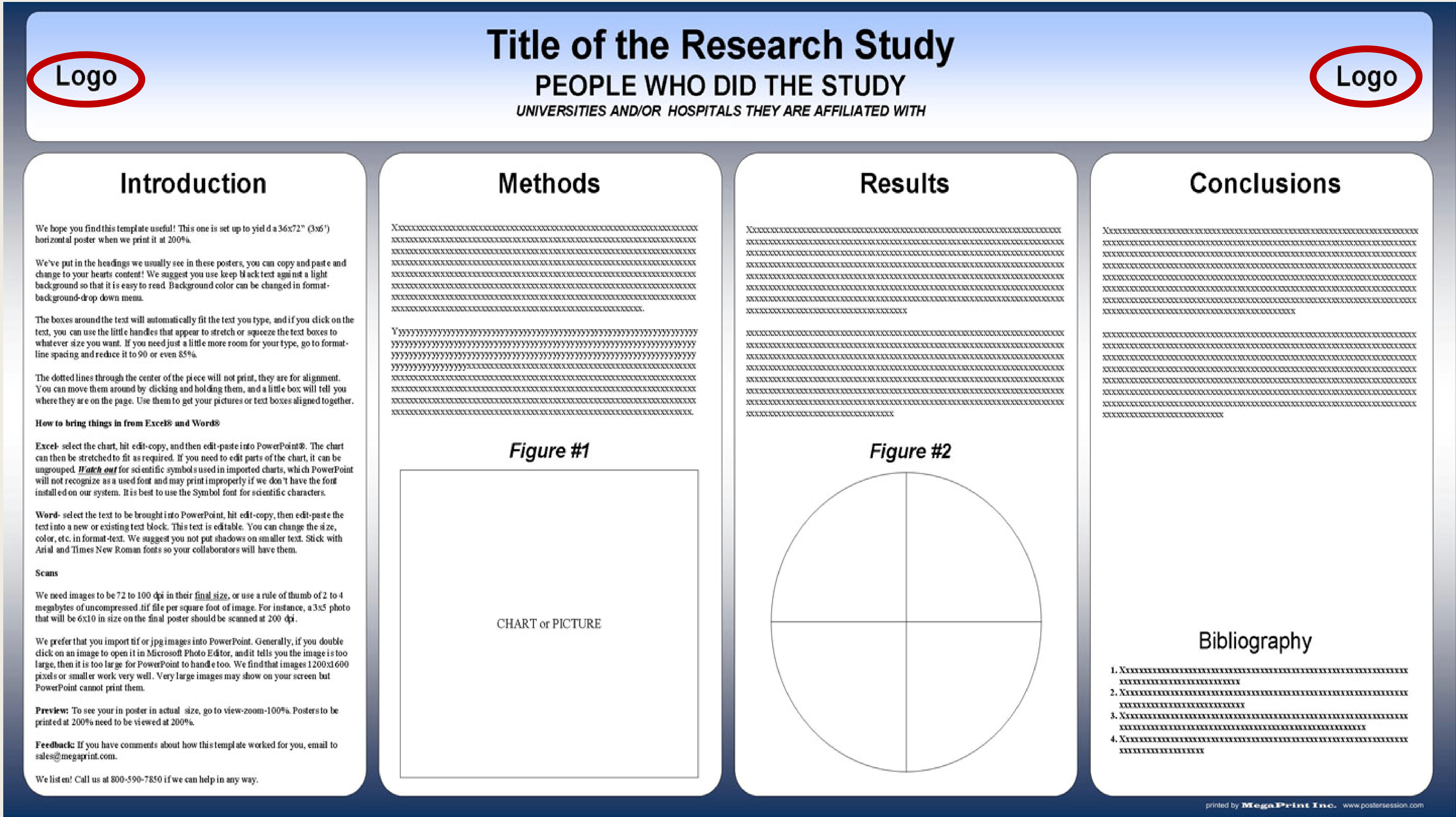
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Results
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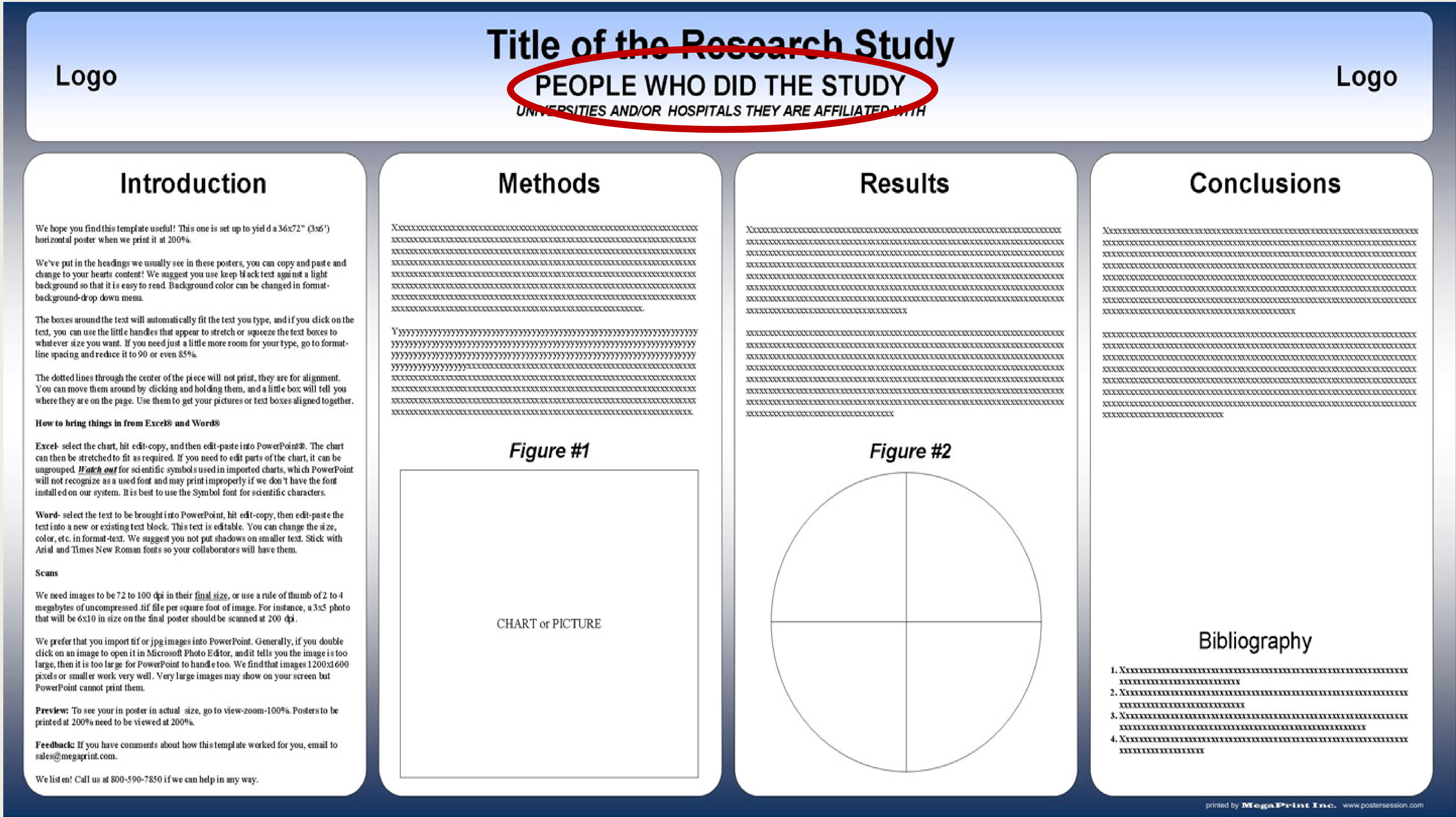

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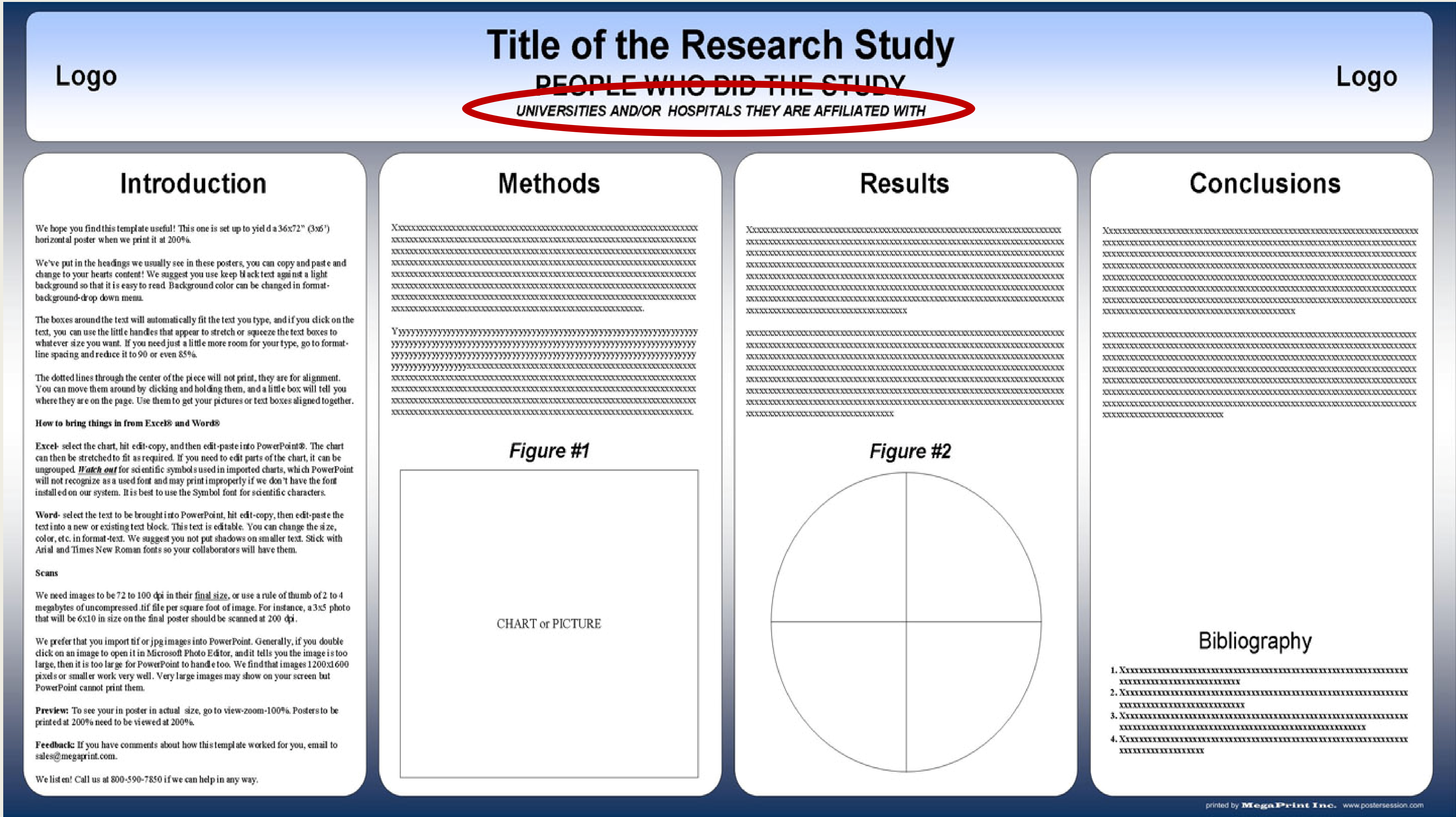

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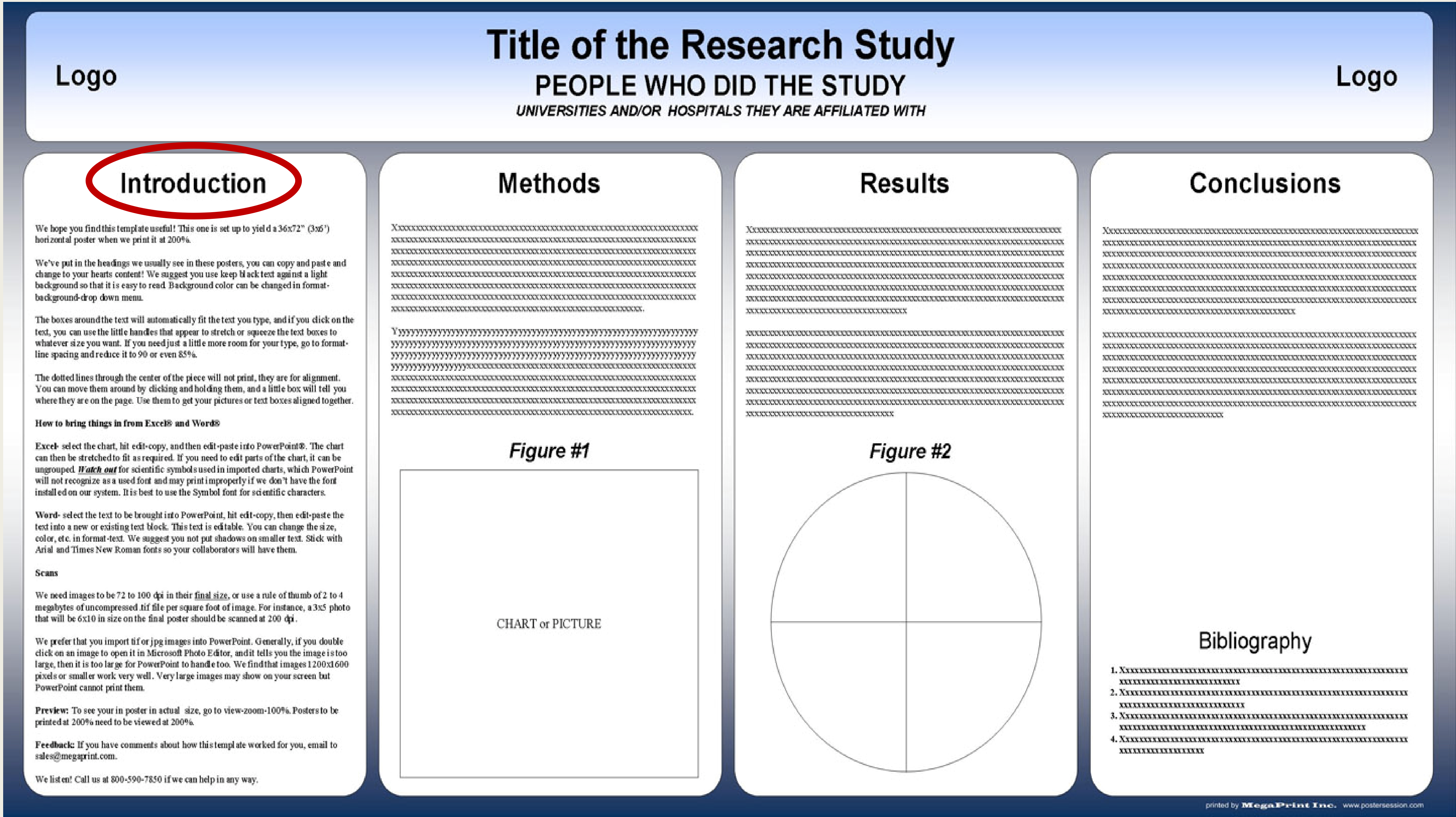

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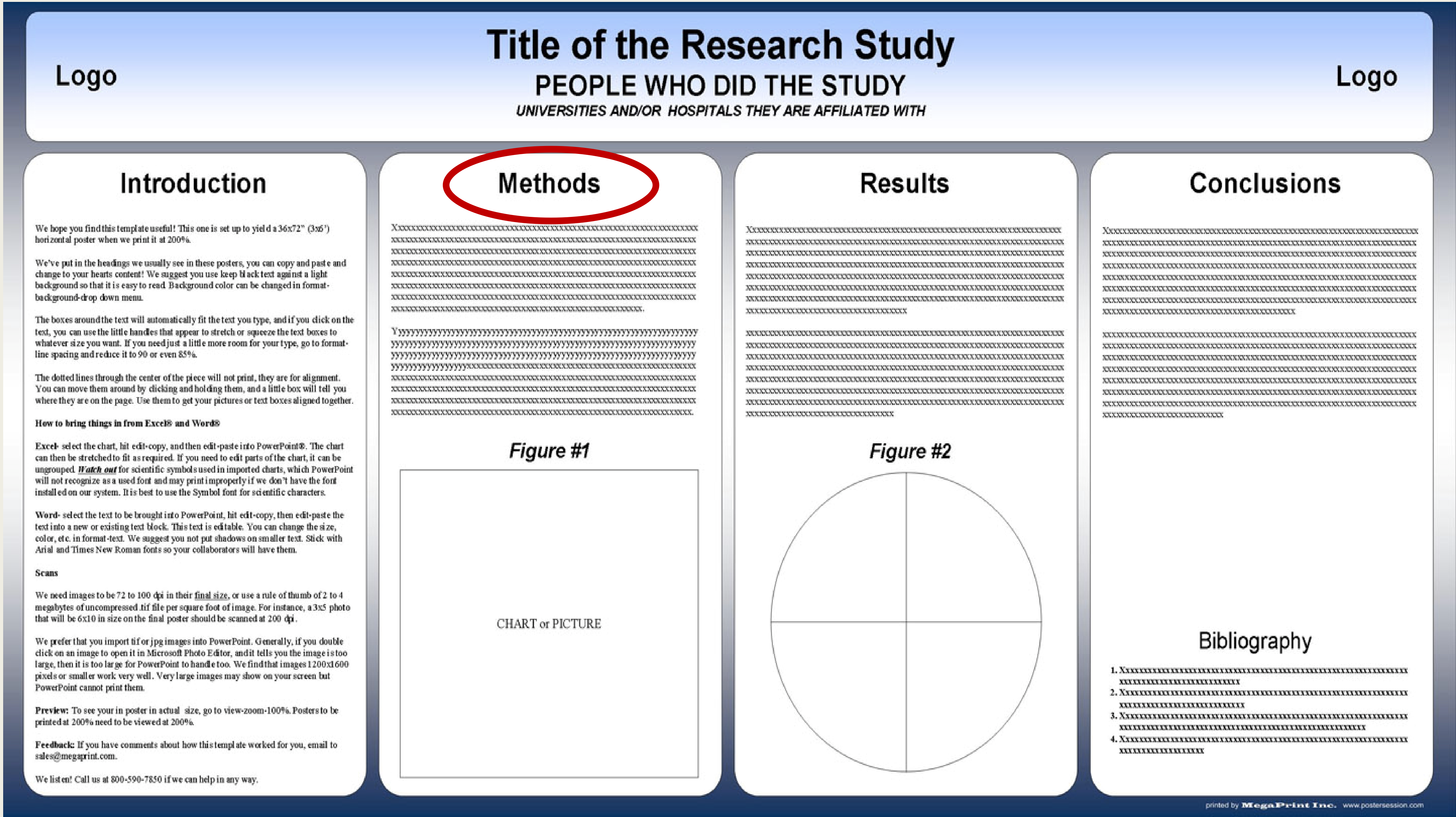
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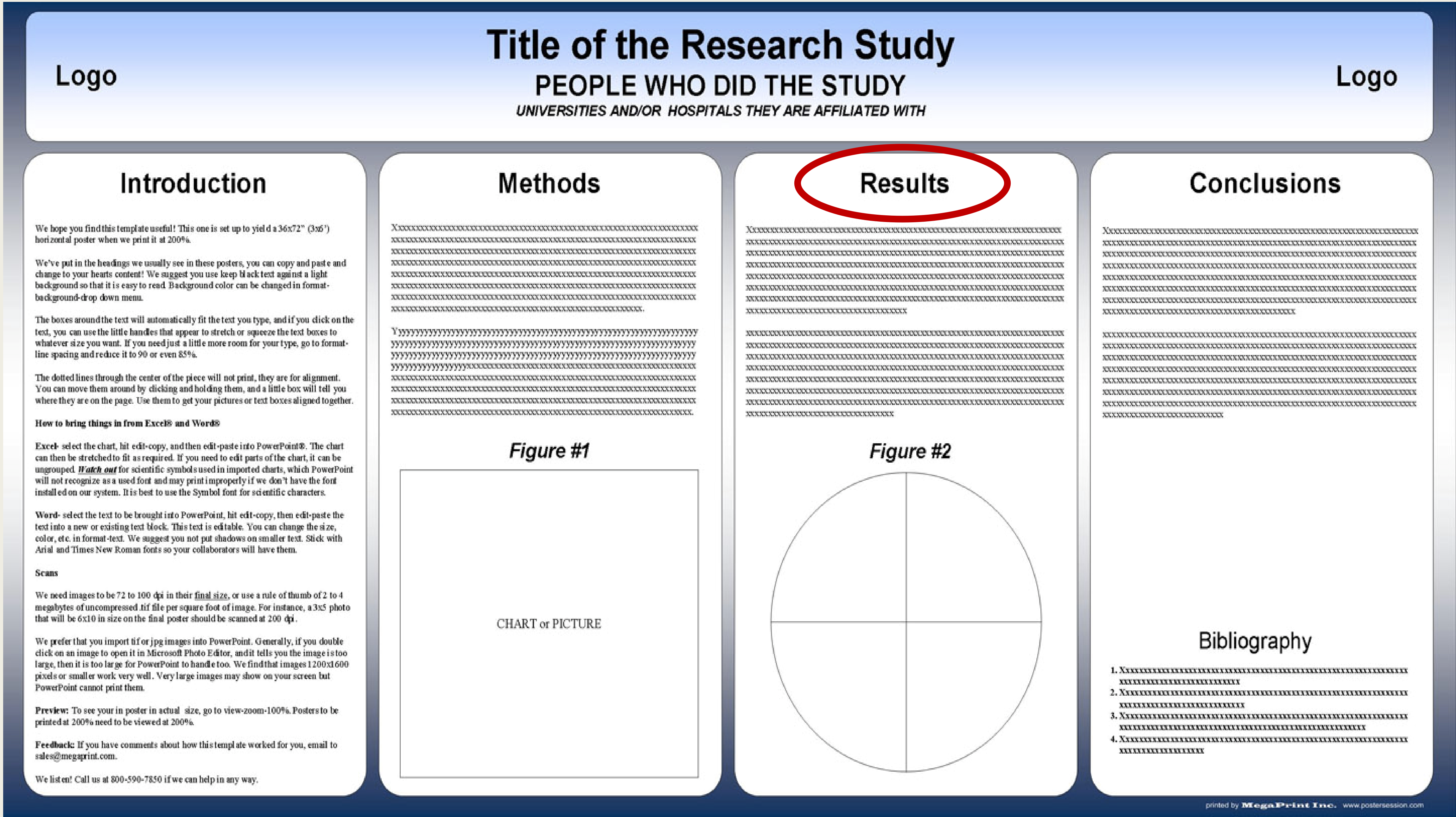

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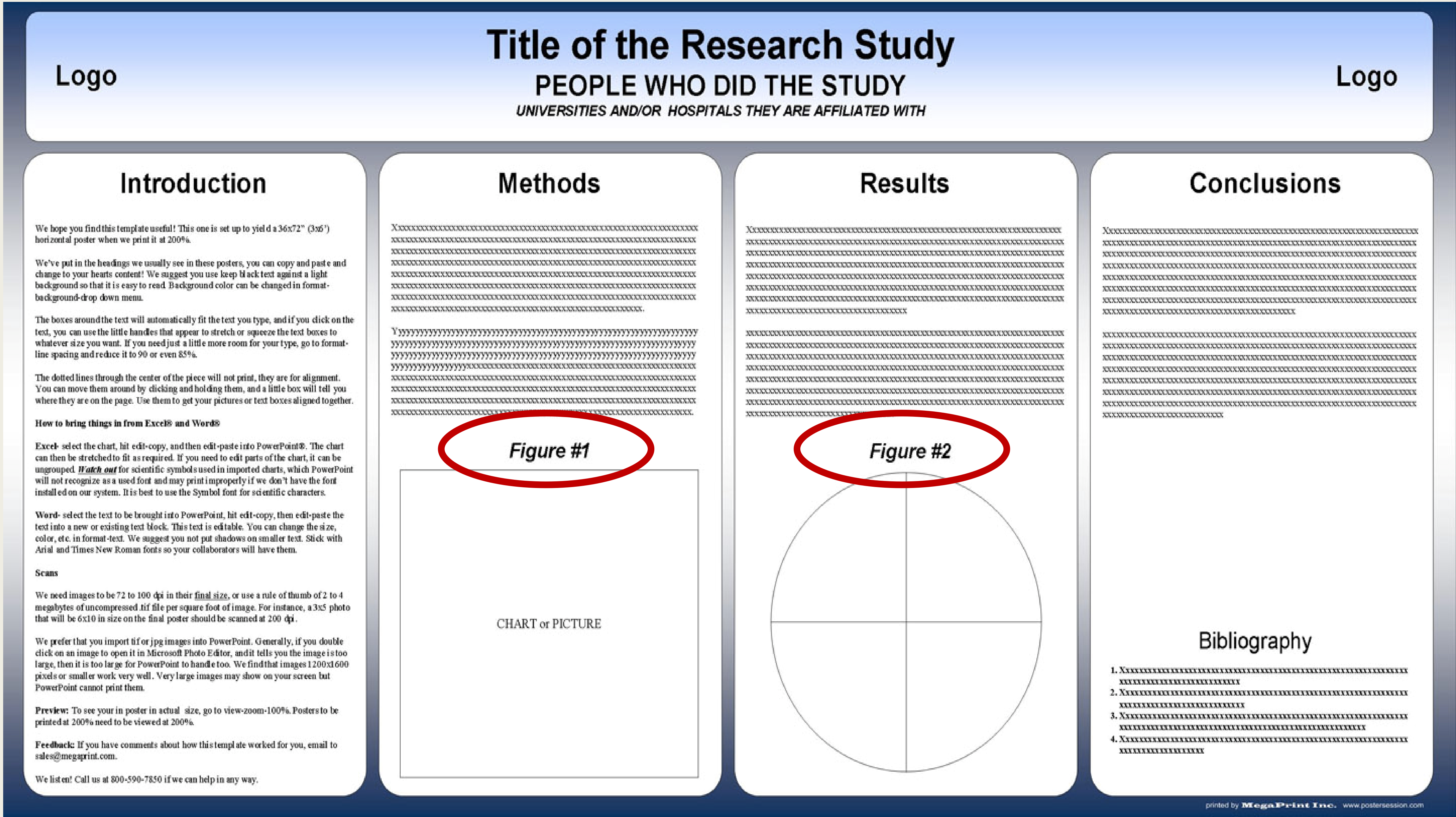

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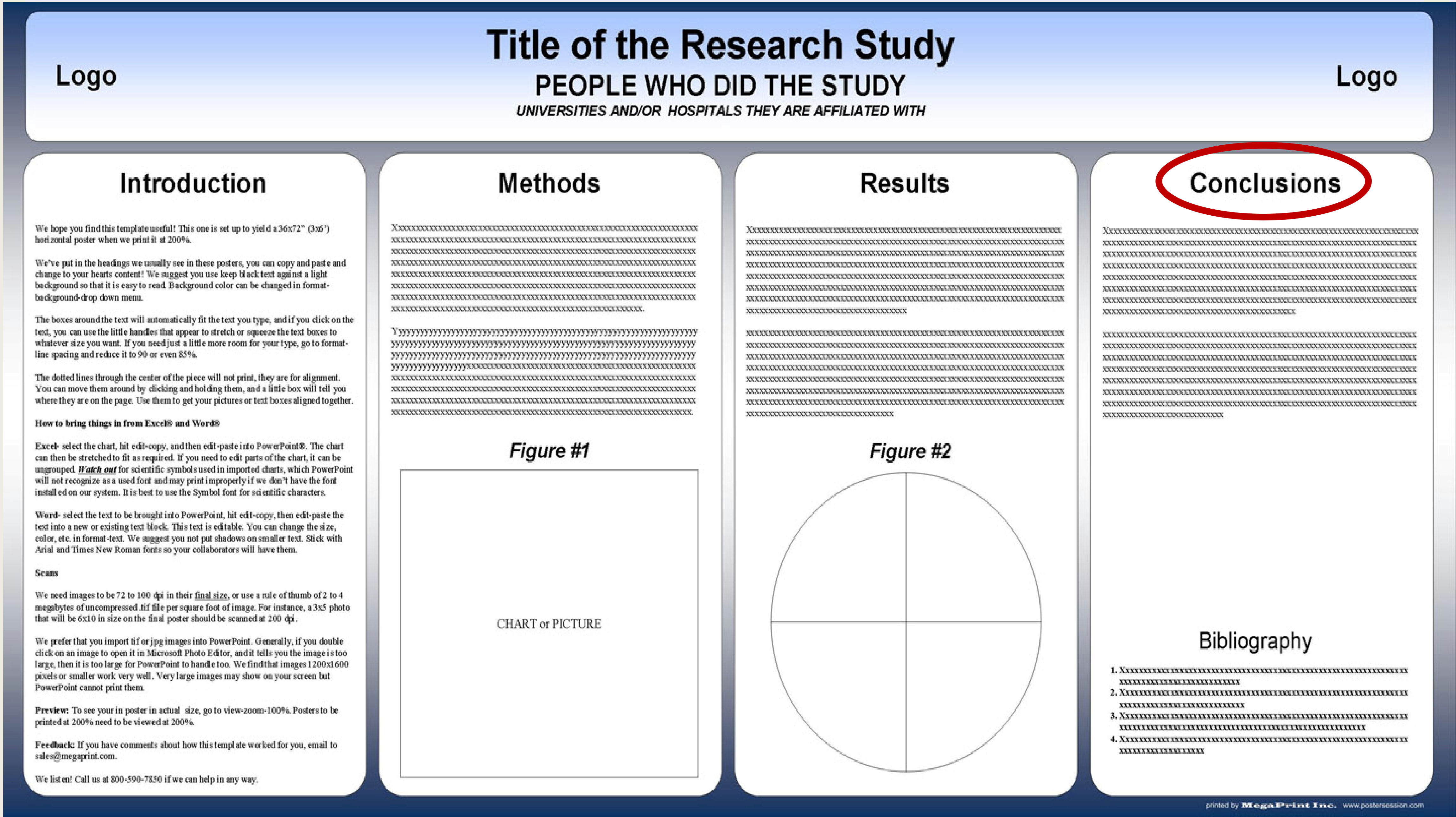

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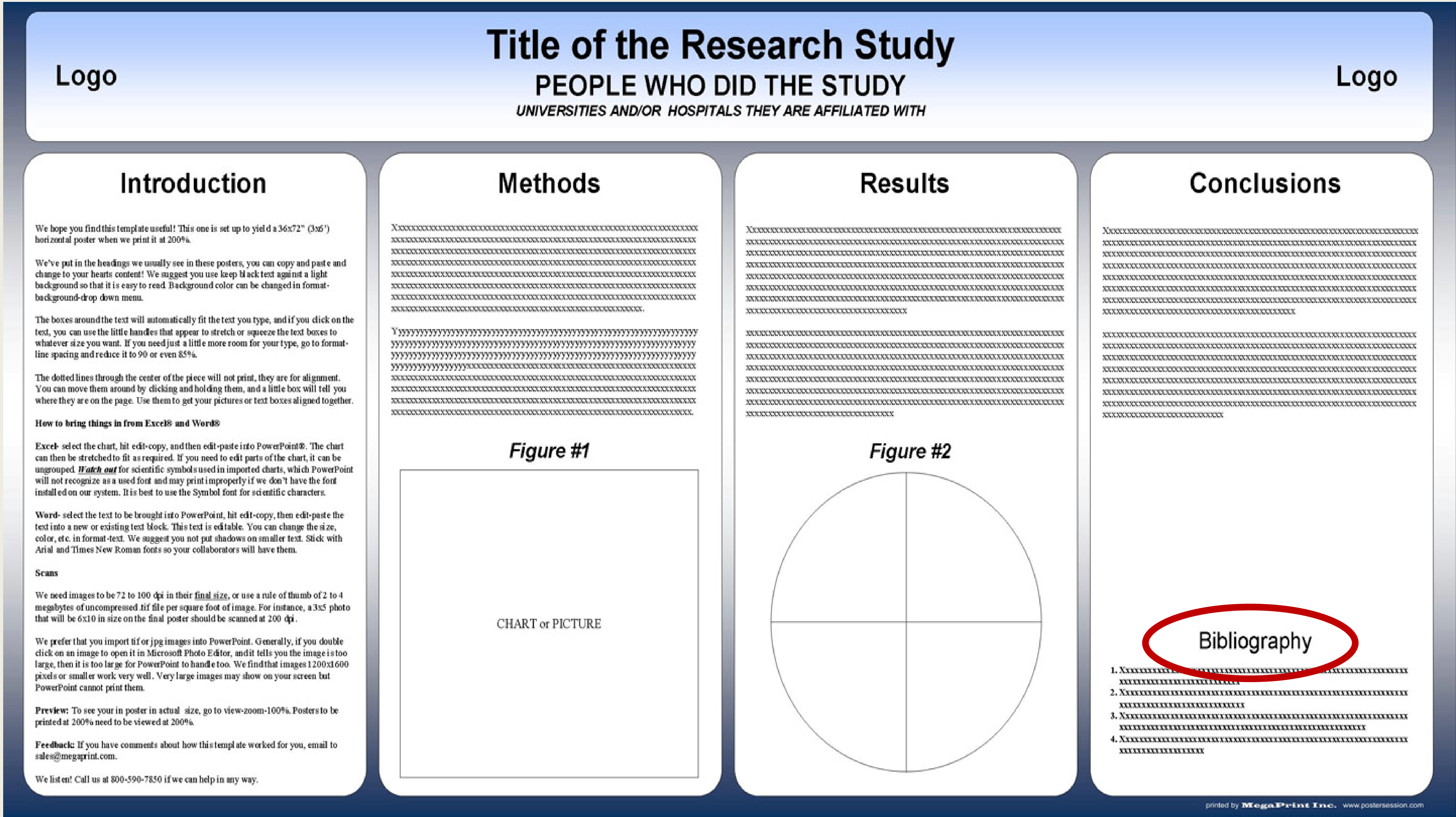
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Preview: To see your in poster in actual size, go to view-zoom-100%. Posters to be printed at 200% need to be viewed at 200%.
Feedback: If you have comments about how this template worked for you, email to sales@megaprint.com.
We listen! Call us at 800-590-7850 if we can help in any way.
Methods
Figure #1
CHART or PICTURE
Results
Figure #2
Conclusions
Bibliography
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CLINICAL VIGNETTE POSTER

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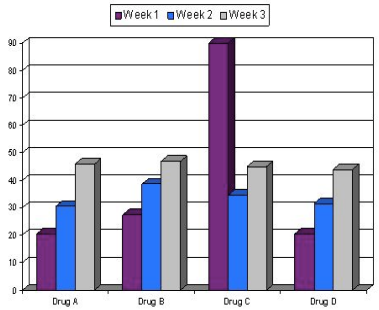

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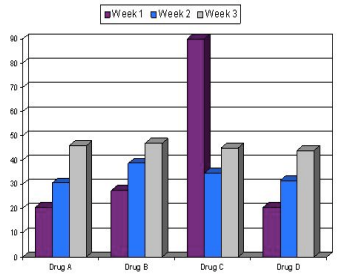

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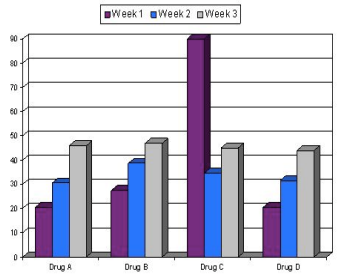

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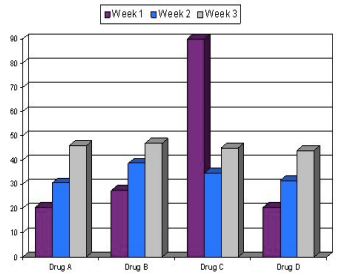

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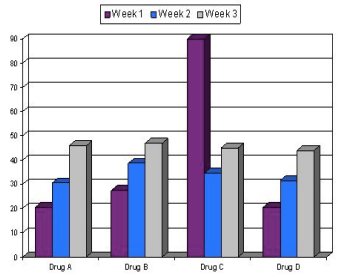

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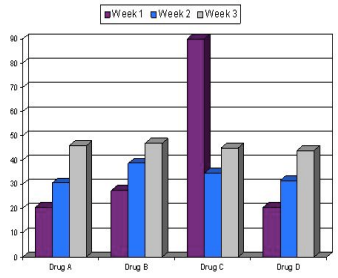

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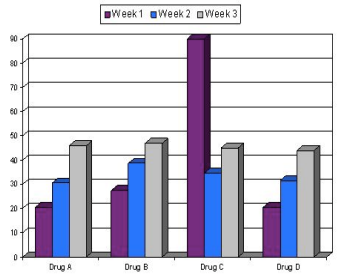

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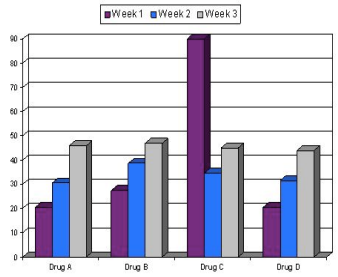

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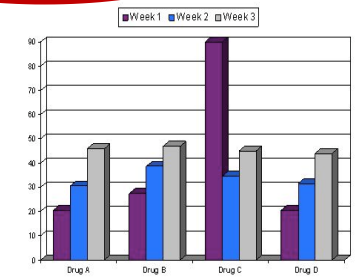

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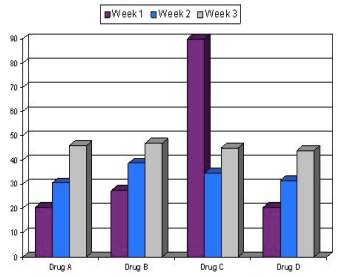

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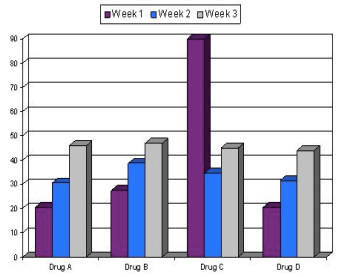

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Figure 1

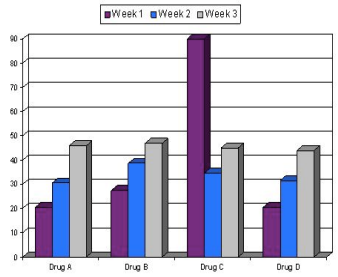

Figure 2

Digital or scanned image:
JPEG or TIFF format preferred,
200 ppi max. resolution

Captions should be set in Times or equivalent, 14 to 18 points, to the width of the column when a figure takes more than 2/3 of the column width.

Discussion

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Conclusions

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References

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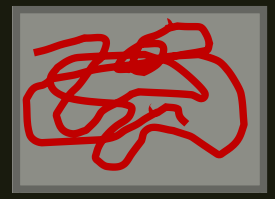
Acknowledgements

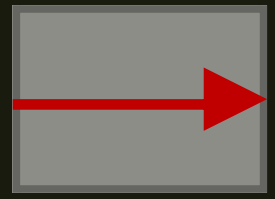
…k everyone who helped with this proj…

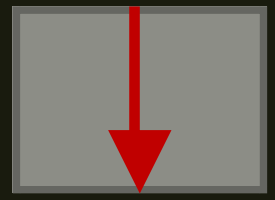
Also acknowledge grants or other financial contributions regarding this research.

TIPS

- Avoid Clutter
- Left to Right
- Top to Bottom







- Emphasize important points
  - *lines, frames, boxes, arrows*
- Ensure font is smaller throughout
- Use no more than three font sizes
- Not overly dense
- Easy to read

- Short title to draw interest/attention getter
- Concise information
- Graphics communicate data
- Content can be absorbed in 10 minutes or less

VISUALS

- Pictures
- Charts
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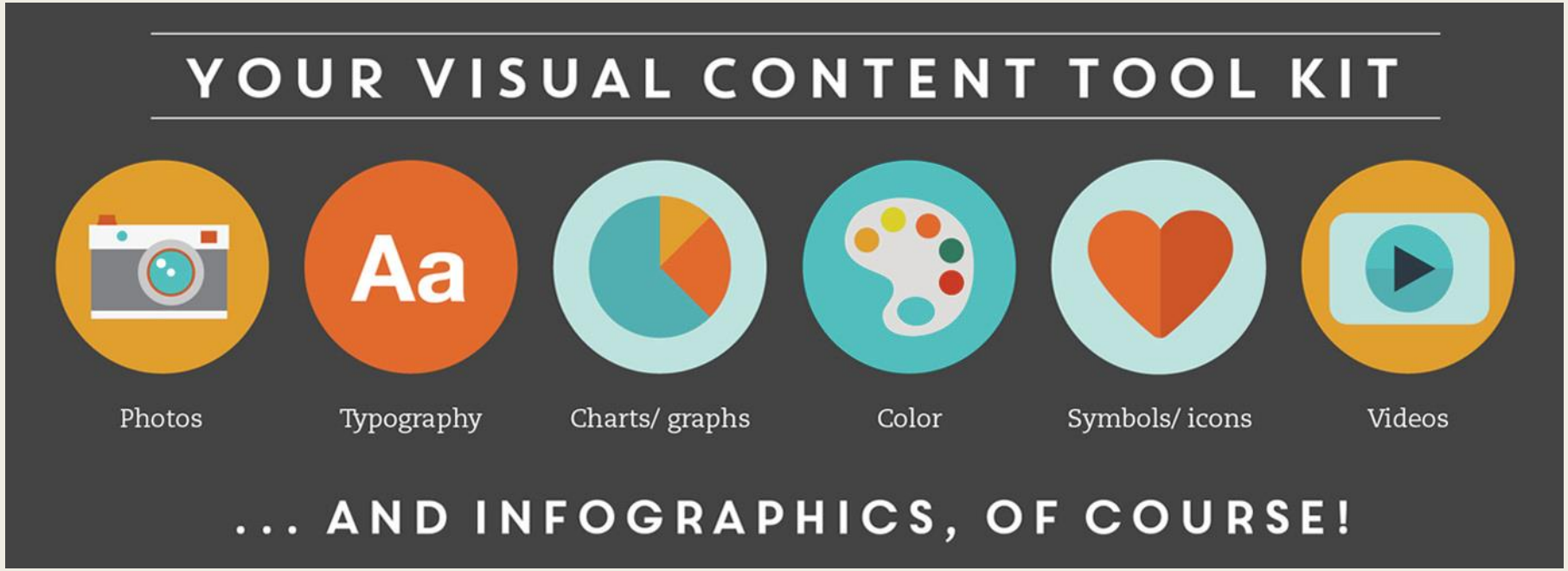
- Graphs
- Pie Charts
- Photographs



COLOR USE

- Too much color can be distracting
- Too little color can be boring and lifeless
- Use color to highlight important elements

“TEN SIMPLE RULES FOR A GOOD POSTER PRESENTATION”

Rule 1: Define a Purpose

Rule 2: Sell your work in 10 seconds

Rule 3: The Title is important

Rule 4: Poster acceptance means nothing

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1876493/

“TEN SIMPLE RULES FOR A GOOD POSTER PRESENTATION”

Rule 5: Similar rules to writing a paper

- Identify Audience
- Succinct Summary of Information

Rule 6: Distill information, don’t lose the core message

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1876493/

“TEN SIMPLE RULES FOR A GOOD POSTER PRESENTATION”

Rule 7: Layout and Format are critical

Rule 8: Content is important, be concise

Rule 9: Posters should show your personality

Rule 10: Ensure presenter and audience interaction

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RESEARCH STUDY:
POSTER EXAMPLES

Incidence of Repeat Emergency Department Visits in Patients with or without Primary Care Physician Follow-Up

Maricel Dela Cruz, DO, MPH, Julia Todd, DO, Rebekah Varzally, DO, Aekata Shah, DO, Robert Danoff, DO, FACOFP, FAAFP

Aria Jefferson Health, Department of Family Medicine

ABSTRACT

Preventing avoidable readmissions is paramount and leads to improved quality of care as well as decreases in health costs. Studies have shown that primary care follow-up after emergency department discharge decreases repeat visits to the hospital. [3,4] It is our belief that patients with documented primary care providers have less repeat emergency department visits relative to their counterparts without primary care providers. In particular, resident teaching offices fare better than non-teaching primary care offices. A retrospective observational study was conducted using Sunrise inpatient data from January 2015 to December 2015 at two affiliated community hospitals in Pennsylvania. This data analysis revealed that our readmission and repeat emergency department visits were similar to national averages. Teaching offices, which consist of resident providers, had lower readmission rates. Further research is warranted to determine barriers to care and differences between teaching and non-teaching primary care offices.

BACKGROUND

In 2010, over 35 million hospital discharges occurred in the United States and roughly 20 percent of Medicare patients were readmitted within 30 days.[1] The cost of these events reach $17 billion annually.[2] Preventing avoidable readmissions is paramount and leads to improved quality of care as well as decreases in health costs. Studies have shown that primary care follow-up after emergency department discharge decreases repeat visits to the hospital. [3,4] Multidisciplinary systems have shown that early primary care follow-up leads to decreased admission rates.[5-7]

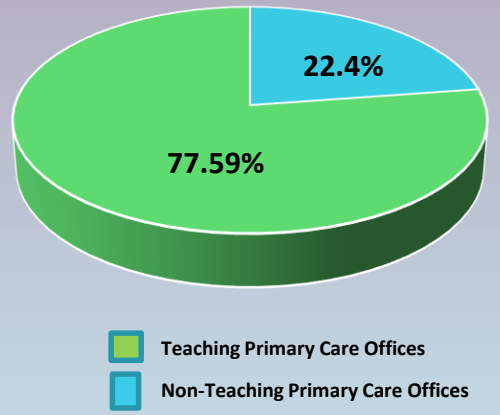
HYPOTHESIS

It is our belief that patients with documented primary care providers have less repeat emergency department visits relative to their counterparts without primary care providers. In particular, resident teaching offices fare better than non-teaching primary care offices.

METHOD

A retrospective observational study was conducted using Sunrise inpatient data from January 2015 to December 2015 at two affiliated community hospitals in Pennsylvania. Individual records were retrieved from emergency department visits and screened for repeat hospital visits in patients with and without primary care follow-up as well as teaching versus non-teaching offices. A comparison of repeat hospital visits was made between the two populations.

REPEAT EMERGENCY DEPARTMENT VISITS



RESULTS

Among 2,007 visits reviewed there was a combined readmission rate of 27.72%. Of those who were readmitted, 7.55% did not have a primary care physician listed while 92.43% of readmits did. Of those readmits who did have a primary care physician, 22.4% were from a teaching office compared to 77.59% from non-teaching offices (Figure).

CONCLUSION

One third of 65.5 million emergency department visits from 2006-2007 had repeat visits – the absence of a primary care provider was one factor associated with revisits.[8] This data analysis revealed that our readmission and repeat emergency department visits were similar to national averages. Teaching offices, which consist of resident providers, had lower readmission rates. This may be attributed to continuity of care in that resident physicians often participate in including inpatient, outpatient, and emergency medicine care. Further research is warranted to determine barriers to care and differences between teaching and non-teaching primary care offices. Bridging these gaps with a strong transition of care between outpatient and inpatient teams will be vital in the future of reducing readmission rates.

ACKNOWLEDGEMENT

This was a retrospective observational study and permission was granted for data collection and analysis by Aria Jefferson Health.

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Incidence of Delayed Intracranial Hemorrhage in Patients Taking Warfarin that Sustain Head Trauma

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Aria Jefferson Health, Department of Emergency Medicine, Philadelphia, PA, United States

INTRODUCTION

With an aging United States population, individuals taking anticoagulant medications, specifically warfarin, are common. A large proportion of the elderly and those in lower socioeconomic classes utilize warfarin due to its affordability. Emergency medicine physicians are challenged in treating these patients after they sustain head trauma. It is agreed that the overall mortality in anticoagulated patients is significantly higher in patients on warfarin versus non-anticoagulated patients (6, 12). Of particular interest is the incidence of delayed intracranial hemorrhage in patients with blunt head trauma while on warfarin. To date, there is limited data on this matter.

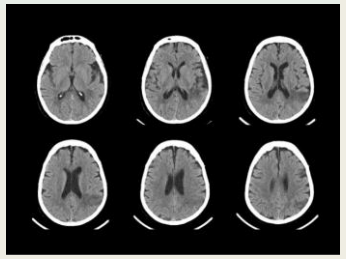


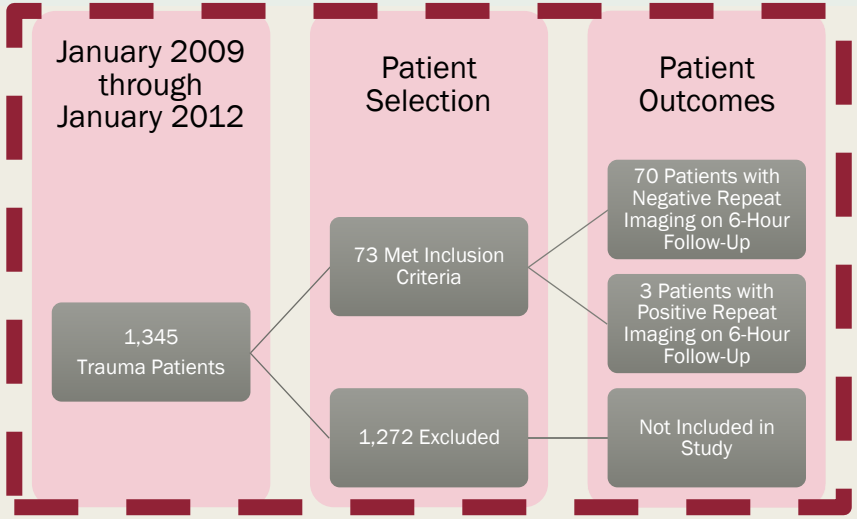
Figure Normal Computed Tomography of the Brain.

OBJECTIVES

The objective of this study was to determine the incidence of delayed intracranial hemorrhage by computed tomography in individuals taking warfarin. It is hypothesized that the incidence of delayed intracranial hemorrhage in this specific population is low. As a result, this data can potentially prevent unnecessary admissions to the hospital, decrease radiation exposure, and reduce costs.

MATERIALS AND METHODS

A retrospective observational study was conducted using the following software: Wellsoft ED charts, Allscripts Sunrise inpatient data and radiographic studies on PACS from January 2009 to January 2012 at a Level II community trauma center, Aria Health Torresdale in Philadelphia, Pennsylvania. The Aria Health IRB approved this study. Participants included individuals admitted to the trauma service that were taking warfarin, suffered blunt head trauma, and had an initially negative CT Brain. Patients had to be 18 years or older to be eligible. There were no interventions performed, as this was a retrospective analysis.



RESULTS

The primary outcome of this study was to determine the incidence of delayed intracranial hemorrhage in patients sustaining blunt head trauma while anticoagulated on warfarin from 2009 to 2012. In this chart review study, there were several thousand patients admitted to the trauma service during the time span of interest. Of those, 73 patients were admitted to the trauma service that satisfied this study's inclusion criteria. There were a multitude of blunt traumatic mechanisms of injury, including but not limited to, accidental falls, syncope, assaults, and MVCs. These patients were anticoagulated on warfarin for a variety of reasons, most commonly for atrial fibrillation. In this cohort, there were three patients who had an initially negative CT Brain that then developed an intracranial hemorrhage as demonstrated upon a 6-hour follow-up CT scan. The remaining 70 patients had negative imaging on a 6-hour follow-up CT Brain.

CONCLUSIONS

There is a risk of delayed intracranial hemorrhage in individuals using warfarin. This study found that none of the three patients with delayed intracranial hemorrhage had a significant change in their clinical status. No neurosurgical intervention was required. While there is a slight risk of delayed hemorrhage in this patient population, the most appropriate management may be to monitor these patients for clinical status change and only then could the decision for repeat imaging be made. On a systems-wide scale, this has the potential to decrease spending on imaging and reduce unnecessary radiation exposure.

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The authors of this presentation do not have any disclosures.

CLINICAL VIGNETTE:
POSTER EXAMPLES

The Paradoxical Effect of Alendronate Use

Maricel Dela Cruz, DO, MPH and Robert Danoff, DO, MS, FACOFP, FAAFP
Aria Jefferson Health, Department of Family Medicine

ABSTRACT

Bisphosphonates are a mainstay treatment for osteoporosis.[1,2] Rarely, bisphosphonates may lead to the detrimental side effect of unsatisfactory repair of the bony matrix.[1,3] This case describes the paradoxical adverse effect of atypical femur fracture with prolonged alendronate use in an eighty-one year-old. Fragility fractures are a subtype of pathologic fractures that result from normal activity or falls from standing.[10,11] Family physicians should also be cognizant of the difference between simple fragility fractures versus the wider spectrum of pathologic fractures.

INTRODUCTION

Oral bisphosphonates are a mainstay treatment for osteoporosis.[1,2] Bisphosphonates inhibit osteoclast activity, reduce bone resorption and turnover, and sometimes, lead to the detrimental side effect of unsatisfactory repair of the bony matrix.[1,3] Bisphosphonates are often used in postmenopausal women to decrease the risk, and potentially prevent, hip and vertebral bone fractures.[4,5] This case describes the paradoxical adverse effect of atypical femur fracture with prolonged alendronate use.

CASE SUMMARY

An eighty-one year-old female presented to the emergency department for right leg pain after a mechanical fall. She denied chest pain, shortness of breath, loss of consciousness, or head injury. The patient had a past medical history of osteoporosis, hypertension, hypercholesterolemia, and gastroesophageal reflux disease. Medications included daily carvedilol, lisinopril, ranitidine, and simvastatin, as well as a nearly five-year use of weekly oral alendronate. Vital signs were normal and the remainder of review of systems was negative. Examination revealed an obvious deformity to the right mid-thigh.

INVESTIGATIVE STUDIES

Radiography of the right femur was significant for a transverse fracture of the mid-shaft (Figures 1-3).

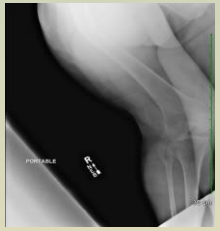

Figure 1
AP view of mid-shaft fracture, right femur.

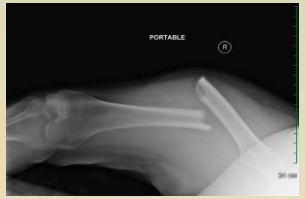

Figure 2
Lateral view of mid-shaft fracture, right femur.

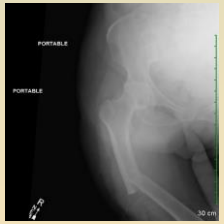

Figure 3
Right hip film with visualized right femur mid-shaft fracture.

OUTCOME

The diagnosis was a simple fragility fracture secondary to a history of osteoporosis and fall from standing. Subsequently, the patient underwent open reduction and internal fixation and upon discharge was kept on alendronate. It was not until the patient was evaluated by her family physician that she was instructed to discontinue alendronate, which likely lead to her atypical fracture.

DISCUSSION

This case demonstrates the adverse effect of a diaphyseal femur fracture with long-term use of alendronate. Though rare, several cases have been documented in the literature displaying atypical femur fractures with prolonged alendronate use.[6-9] Pathologic fractures are typically caused by secondary etiologies that lead to weak bone structure.[10,11] Fragility fractures are a subtype of pathologic fractures that result from normal activity or falls from standing.[10,11] Because of these concerns, it is important for family physicians to instruct patients taking oral bisphosphonates to discontinue use within five years as per the recommended guidelines in preventing associated atypical fractures.[1] Family physicians should also be cognizant of the difference between simple fragility fractures versus the wider spectrum of pathologic fractures.

REFERENCES

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Putting a Strain on my Heart

Maricel Dela Cruz, DO, MPH[1], Jeremy Seldinger-Devey[2]
Aria Jefferson Health[1], Gallup Indian Medical Center[2]

CHIEF COMPLAINT

Shortness of breath.

HISTORY OF PRESENT ILLNESS

A 58-year-old Native American female presented to the emergency department (ED) with a 3-month history of progressive shortness of breath, orthopnea, and dyspnea upon exertion. Initially, the patient experienced only mild exercise intolerance, but by the time of her presentation to the ED, she noted that she was becoming winded after only a few steps. The patient's orthopnea had become so intolerable that she now slept upright in a recliner every night.

Associated symptoms included paroxysmal nocturnal dyspnea and a non-productive cough. The patient denied chest pain, lower extremity edema, weight loss, or episodes of syncope. The patient had seen her primary care provider several times for these symptoms. Her outpatient doctor performed a chest x-ray, diagnosed bronchitis, and arranged a sleep study that had not yet been performed. The patient's only known medical problem was gastroesophageal reflux disease for which she was taking omeprazole. The patient had no surgical history, medication allergies, drank no alcohol and did not smoke or use illicit substances.

PHYSICAL EXAM

Upon examination, the patient was not in acute distress. Vital signs including blood pressure, temperature, heart rate, respiratory rate, and pulse oximetry were all within normal limits. The cardiovascular exam demonstrated a regular rate and rhythm with no audible murmurs, gallops, or rubs. There was no jugular venous distension. There was trace lower extremity edema at the right pretibial region. Lung sounds were clear bilaterally, and there was no respiratory distress. The remainder of the physical exam was normal.

INVESTIGATIVE STUDIES

Laboratory workup included a metabolic panel and a complete blood count that were unremarkable, as well as a D-Dimer which was elevated at 1,345 ng/ml. The patient's electrocardiogram revealed T-wave inversions in leads V1 through V3 with extreme right axis deviation.

Chest X-Ray demonstrated a small right pleural effusion.

QUESTIONS

1. What are the abnormalities visualized in Figures 1 and 2.
2. What are T-wave inversions in the precordial leads (V1-V3) and right axis deviation on EKG indicative of?

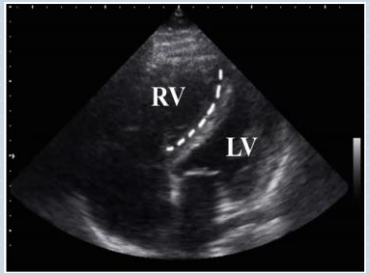

Figure 1

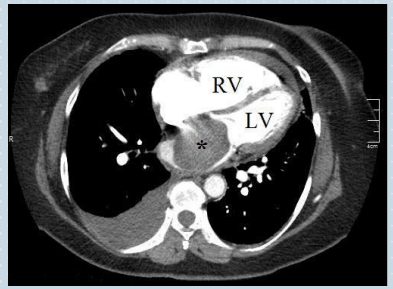

Figure 2

ANSWERS

1. Figure 1: Grossly dilated right ventricle and bowing of the intraventricular septum into the left ventricle. RV = Right Ventricle. LV = Left Ventricle.

Figure 2: CTA was negative for pulmonary embolism, but did demonstrate a 6.3 x 4.3 cm filling defect of the entire left atrium that was suspicious for cardiac tumor. A right pleural effusion was also confirmed. RV = Right Ventricle. LV = Left Ventricle.

2. T-wave inversions of the precordial leads (V1-V3), as noted in this case as well as right axis deviation are indicative of right heart strain. Right heart strain is caused by increased pulmonary artery pressures. Causes of right heart strain include, but are not limited to: primary or secondary pulmonary hypertension, pulmonary embolism, chronic right ventricular hypertrophy or dilation, chronic lung disease, congenital heart disease, etc.

DISCUSSION

As with many conditions, pulmonary hypertension (PH) has both primary and secondary causes. Secondary causes include pulmonary thromboembolic disease, congestive heart failure, chronic obstructive pulmonary disease, obstructive sleep apnea, pulmonary fibrosis, connective tissue disease, congenital heart disease, cardiomyopathy, portal hypertension, certain toxins, human immunodeficiency virus, and other infectious causes. Primary cardiac tumors, such as that responsible for our patient's pulmonary hypertension, are extremely rare, often presenting with symptoms that can mimic common diseases that are regularly encountered in the emergency department.

Long-term survival in patients with PH varies according to its etiology. Five-year survival for congenital heart disease with PH approaches 80%, while HIV patient with PH demonstrate only 20% survival at 3 years. The treatment of PH in the emergency department is focused on the underlying etiology and may include afterload reduction for congestive heart failure, emergent thrombolysis for pulmonary embolism, or admission for further evaluation and medical treatment of other forms of PH. For primary cardiac tumors causing PH, surgical resection, and when appropriate, adjuvant chemotherapy have been shown to be the treatments with the best long-term outcomes.

CONCLUSION

The patient was placed on oxygen therapy and admitted to the intensive care unit for close monitoring. She was evaluated by a cardiologist who confirmed PH by formal echocardiography and recommended transfer to a cardiology specialty hospital. The patient was transferred and subsequently taken to the operating room for resection of the left atrial mass. Pathology findings from the mass were consistent with sarcoma, a malignant primary cardiac tumor with an incidence of 0.0001%. The patient underwent post-operative chemotherapy and several months after the surgery had experienced significant improvement in her symptoms.

PEARLS

1. On EKG, right heart strain can be visualized by T-wave inversions in the precordial leads and right axis deviation.
2. ED bedside ultrasound can be vital in recognizing increase pulmonary artery pressure, further directing physicians towards workup, management and definitive treatment.
3. The ED physician should be cognizant of the wide array of differential diagnoses that cause right-heart strain. Prompt recognition is important in the direction of care.

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RESOURCES

- Preparing a poster presentation. American College of Physicians. https://www.acponline.org/membership/residents/competitions-awards/abstracts/preparing/poster.
- How to create a research poster: poster basics. New York University. http://guides.nyu.edu/posters.
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